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ABSTRACT

This guide is designed as a source of ideas and information for individuals and organizations interested in occupational alcoholism programs for the hard-to-reach work force. Following a brief overview of the problem and a report on progress in occupational alcoholism programming, a working definition of the hard-to-reach work force is offered; suggested criteria for defining this type of worker include amount of supervision, employment setting, and organizational affiliation. Programming needs, approaches to the problem, and approach selection criteria for working with three elements of the hard-to-reach labor force (dispersed workers, unionized workers, and white collar professionals) are discussed. Currently operated programs for unionized members of the Longshoreman's Association, the building and construction industries, the Air Line Pilot's Association, and the National Maritime Union are highlighted. The stresses and program needs of lawyers, physicians, and university faculty are discussed. Program startup suggestions are offered for the elements of a policy statement, and for general programming considerations. A list of relevant organizations is provided. A glossary of terms and a list of selected references conclude the document. (BL)

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National Institute on Alcohol Abuse and Alcoholism

Alcohol Abuse in the Hard-to-Reach Work Force

Ideas and Resources for Responding to Problems of the Hard-to-Reach Work Force

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service • Alcohol, Drug Abuse, and Mental Health Administration

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TARGET

Alcohol Abuse in the Hard-to-Reach Work Force

Ideas and Resources for Responding to Problems of the Hard-to-Reach Work Force

U.S. DEPARTMENT OF EDUCATION
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service
Alcohol, Drug Abuse, and Alcohol Abuse and Alcoholism

National Institute on Alcohol Abuse and Alcoholism
5600 Fishers Lane
Rockville, Maryland 20857

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Foreword

Target: Alcohol Abuse in the Hard-to-Reach Work Force was developed by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in support of its long-term commitment to deal with alcoholism in the workplace.

Since its establishment in 1971, NIAAA has provided grants to new and developing occupational programs, staffing grants for State consultants, and has funded research on the needs of special populations in the work force. Meanwhile, the private business and industrial sector, organized labor, and concerned organizations, such as the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) and the National Council on Alcoholism (NCA), have also actively worked to expand program coverage. Between 1950 and 1973, the number of occupational alcoholism programs in the United States grew from 50 to approximately 500; by 1977 nearly 2,400 programs had evolved. Today, more than 5,000 programs operate nationwide providing services to 12 percent of the work force (or 10.5 million employees).

Yet despite this rapid growth of programs, there remains in the field a number of unmet needs. Of these, the needs of the hard-to-reach worker are among the most pressing.

Most occupational programs today rely on close observation of a worker's performance by a supervisor or union steward. Yet there are millions of people in the work force who have little or no contact with a supervisor on a regular basis—lawyers, doctors, dentists, teachers, self-employed business or professional persons, farmers, craftspeople, sales representatives, domestic workers, and transit and construction workers, among others. These individuals are members of the hard-to-reach work force and they span all occupations, all social and all economic strata.

Service to this segment of the labor force is essential if the occupational alcoholism field is to realize its goal of assisting the alcoholic worker, regardless of setting, to return to productive job performance. The establishment of effective referral and treatment mechanisms for the hard-to-reach worker will do much toward meeting this goal. Yet it is not up to the occupational alcoholism field alone to accomplish this. Other key groups play an important role.

Unions, with their historic support of worker health programs, are existing organizational structures that can be utilized to sponsor member alcoholism programs. Some hard-to-reach workers already benefit from these efforts, but there remain many others in need of such services.

Professional organizations and societies are encouraged to establish policies, procedures, and, where appropriate, programs for helping members who have alcohol-related problems. In many cases, an individual's professional affiliation is one of the strongest influences in his/her life. Those national professional organizations that have initiated programs are urged to publicize them and encourage their establishment among affiliated chapters.

Corporations with a dispersed work force can make a major contribution to the welfare of their employees by contracting with service networks, consortia, or community services to provide referral and treatment programs. While many large companies have occupational programs for headquartered employees, their employees in small groups around the country cannot take advantage of these services.

NIAAA, through its Division of Occupational Alcoholism Programs, encourages businesses, industries, and organizations whose employees and members fall into the hard-to-reach category to utilize this publication as a resource in designing alcoholism program services.

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Introduction

Overview

Meeting the alcoholism service needs of hard-to-reach workers is posing a challenge to the occupational alcoholism field. Many persons filling a broad range of jobs do not have ready access to alcoholism services; others have no direct supervisors, the central component of most employee alcoholism programs.

Occupational programmers have become increasingly aware of the needs of the hard-to-reach worker and have taken some innovative approaches to reaching this employed population. The programs described in *Target: Alcohol Abuse in the Hard-to-Reach Work Force* were selected for their possible replication in settings with other hard-to-reach workers. It is understood that particular underserved populations will not be identical to the ones described, but it is hoped that certain program elements may be applicable for the employees in question.

Certainly, many more programs than those presented here are operating today, and planners and concerned organizations and individuals will consult many sources before undertaking service efforts. This booklet is meant to be a springboard for more program ideas; for alternative referral methods involving peers, the worker experiencing the problems, and the supervisor; for helping the problem drinker stay in treatment; and for helping the problem drinker who has no supervisor.

Target: Alcohol Abuse in the Hard-to-Reach Work Force is directed to persons who have a working knowledge of occupational programs as well as to those who are just learning about alcoholism services for workers. A genuine concern for the needs of the hard-to-reach employee or union member with alcohol problems is the most important criterion for reading this booklet.

Although singling out the hard-to-reach for special attention may be a relatively recent phenomenon, occupational alcoholism programs themselves have a fairly long and successful historical development. Viewing hard-to-reach workers within this context is useful background to designing and implementing programs for this population group.

Progress in Occupational Alcoholism Programming

Occupational alcoholism programs have come a long way since E.I. Du Pont established the first program in a major multiplant company in 1943. For many years, negative attitudes about alcoholism and a lack of information about effective techniques to deal with alcoholic workers hindered the full development of programs. In recent years, particularly during the last decade, the cooperative efforts of business, government, volunteers, organized labor, and health professionals have yielded significant progress toward reaching problem drinkers in the workplace. Research has examined many of the early assumptions and theories about the personal and economic costs of alcoholism in the work force, pointing out the devastation of this disease and the need to take corrective action. For instance, a recent report (Francek 1980) of alcoholism and other drug abuse in the workplace revealed:

- Absenteeism rates two or three times the norm
- Use of health care benefits three to four times the norm
- Accident rates three to four times the norm
- Increasing incidents of violence in the workplace

Beyond the known effects, there may be many other hidden costs. Roman (1974) suggests that the costs to the employer are probably much greater than normally calculated.

The disruptive consequences of deviant drinking may far exceed the cost entailed if 4 percent of the work force were absent or simply sat at their jobs and did practically nothing. The very essence of work organizations is the interdependency of job performances. Deviance by one employee may "reverberate" beyond his work station or

desk, sometimes disrupting an entire organization.

As more health professionals have entered the field and as more information about programs has become available, occupational alcoholism programs have changed focus. In the early days of programming, the focus was almost exclusively on alcoholism, and the services established for employees were more frequently referred to as "occupational alcoholism programs." Recently, however, more attention has been paid to the employee assistance program (EAP) that provides, in addition to alcoholism services, counseling and assistance for a variety of other problems that may affect a worker's performance, such as emotional, marital, and financial difficulties.

Earlier programs also depended heavily on Alcoholics Anonymous (AA) for referral and treatment. While AA still takes a prominent role, several other approaches have developed to assist the alcoholic worker, some of which are explained in subsequent chapters of this booklet.

The theme that has been central to all occupational alcoholism programs is the evaluation of a worker's performance. Supervisors or managers are trained to evaluate and document unsatisfactory work performance. Excessive absenteeism, sickness, lateness, or accidents are some of the indicators use to signal a personnel problem. Employees who exhibit declining work performance are confronted by their supervisor on their work performance and given the opportunity to receive assistance from an in-house or a community-based program.

Yet there are millions of workers who have no direct supervisors: doctors, lawyers, independent insurance agents, salespeople, clergymen, and others. Traditional occupational programs based on a supervisor's intervention have difficulty reaching these people. Unique and innovative approaches are needed to reach a significant portion of the work force—the hard-to-reach.

A Challenge to the Field

The hard-to-reach work force needs new and more effective approaches to serve the broad spectrum of occupations that span all social and economic strata. Looking at what some groups have done to meet the needs of this population is a positive first step in beginning to fill this critical service gap.

1944 DuPont establishes the first known alcoholism program in a major multiplant company.

1944 National Council on Alcoholism (NCA) established.

1944 Eastman Kodak establishes the second major multiplant company program, handled through the medical department with heavy use of Alcoholics Anonymous (AA).

Definition of the Hard-to-Reach Work Force

Definitional Problems

As with any evolving field, employee alcoholism programs have generated their own lexicon of terminology to describe both the workers themselves and the programs that serve these individuals. Because a diverse constituency is involved—organized labor, Federal, State, and local government, management, relevant associations such as the Association of Labor-Management Administrators and Consultants on Alcoholism, the Occupational Program Consultants Association, the National Council on Alcoholism, and others—many definitions have sprung up, reflecting various orientations. Attempts at defining the hard-to-reach worker, then, will surely not meet the needs of all groups concerned, but are a beginning and will no doubt be amended as this booklet is read and used by the alcoholism programming field. Of importance to the issues and programs discussed in the following pages (and to the field as well) are a working definition of the hard-to-reach employee and terms for describing service programs for these individuals.

A factor to consider in developing a definition of the hard-to-reach is the distinction between occupational groups that are hard-to-reach in terms of identification of drinking problems and groups that are hard-to-reach for delivery of services. Persons whose jobs demand considerable mobility such as truck drivers, long-distance bus drivers, and itinerant salespeople may be hard to identify for alcohol problems because of little regular contact with a supervisor or union steward. Delivery of services to these individuals may also be difficult since they do not remain in one location long enough to regularly follow a treatment plan. Other workers, such as physicians and lawyers, tend to work within a limited geographic area and may not be difficult to reach for delivery of services, but protective relationships among colleagues may hinder the identification process. As appropriate, chapter introductions address the issue of hard-to-reach for identification versus hard-to-reach for service delivery.

Worker alcoholism programs have been known for many years as occupational alcoholism programs, and those that offered other services, such as counseling for marital, emotional, or financial problems have been called employee assistance programs. Numerous other terms have also evolved, some thought to connote a management-specific orientation or a union-specific orientation. To avoid confusion in this booklet, the term "employee alcoholism program" will be used to mean a worker health program affiliated with an organization—corporation, union, peer association, or similar structure—and that offers alcoholism services. Alcoholism programs also offering counseling for marital, emotional, financial, and other problems will be referred to

1947 International Doctors in AA established.

1956 American Medical Association recognizes alcoholism as a disease.

1959 NCA estimates that 50 companies have formal programs in full operation. The stereotype of the alcoholic person beyond help remains a deterrent to new program initiatives.

1960 NCA Industrial Committee established (later called Labor-Management Committee).

1965 NCA study indicates programs should place focus on job performance for the purpose of early identification of alcoholic employees.

as " employee assistance programs." Union programs that provide alcoholism and may provide other services will be termed "member assistance programs."[1] Additional definitions are offered in the Glossary.

Characteristics of the Hard-to-Reach Worker

A central component of most employee alcoholism programs is the evaluation of work performance by a supervisor or shop steward. Some occupations, of course, involve less supervision than others. The amount of supervision, the employment setting, and the existence of an organizational affiliation are useful criteria for defining the hard-to-reach worker.

- *Amount of supervision*. Employed persons such as those in manufacturing or secretarial work will generally see a supervisor on an everyday basis. The frequent presence of a supervisor is a necessary component of alcohol programs that document work performance. The self-employed such as physicians, unless they work in a group practice or for a health maintenance organization, in a primary care facility, or in an outpatient clinic in a hospital, will never report to a supervisor. Owners of small businesses are also in this category, which is often characterized by lack of ongoing supervisor-subordinate relationships.
- *Employment Setting*. Numerous large companies (or similar parent organizations) operate small branch offices or divisions in different parts of the country. Often there is little contact with the parent company. The employees, dispersed in various locations, cannot participate in certain company benefits such as employee alcoholism programs. This dispersed work force includes employees in franchise operations and retail food merchandise chains. Another category of workers are those in the mobile work force that includes certain industries such as commercial shipping. Here individuals periodically report to the union hall where a dispatcher or business agent assigns workers to particular jobs, in this case, merchant seamen. Multiple locations and multiple employers are usually the rule, making a centrally located alcoholism program operated by management impractical. This mobile work force, those whose job requires a great deal of travel and whose work setting is not limited to one location, includes merchant seamen, truck drivers, itinerant salespeople, and many others.
- *Organizational Affiliation*. Many persons are affiliated with organizations such as unions, peer associations, and vocational/professional associations, formed to further the development of their membership's interests. Organization affiliations are existing structures that may be tapped to support alcoholism programs for members. Union, society, and association members may become aware of colleagues with alcohol problems and help these persons to obtain treatment under the auspices of the organization or as concerned peers.

As a way to begin discussing, planning, and implementing programming efforts for the hard-to-reach, it is essential that a preliminary definition be adopted. Thus, the following description of the hard-to-reach work force is proposed:

> The universe of employed and self-employed workers, who, for various reasons, are not routinely serviced by performance-based employee alcoholism programs; this group may include members of the dispersed work force, the mobile work force, and other professions characterized by little or no supervision.

[1] It should be noted that not all union programs use the term "member assistance" in the title of their programs.

The Dispersed Work Force

Programming Needs

What does Joe Lange, a chemical worker, do when he develops an alcohol problem? His company operates an employee alcoholism program in its New York headquarters, but not in California where Joe is employed.

Where does Sarah White, manager of a two-person catalogue store in North Carolina, go for help with her alcohol problems?

Programming Barriers

- Limited number of workers in one location
- Long distances to corporate headquarters
- Limited resources of small business

Both Sarah and Joe are part of the dispersed work force, a term used to describe an employee population that is largely underserved by employee alcoholism programs. Because of the great distance to corporate headquarters and the small number of workers at any one location, there is no practical way for these employees to take advantage of a highly desirable employee benefit. Employees in this situation constitute a sizeable portion of the work force, including those working in fast food industries, franchised hotels and motels, and small distribution centers for national products. A subset of this population, the mobile work force—for example, railroad workers, truckers, and bus drivers—encounter similar and oftentimes greater difficulties in obtaining alcoholism services. The job responsibilities of these individuals take them to many locations, discouraging traditional methods of identification, referral, followup, and aftercare.

Members of the dispersed work force are hard-to-reach for identification of alcohol problems, given their employment in settings with little or no supervision or in scattered locations. They are also hard-to-reach for delivery of services since scattered locations with few employees make individual programs impractical.

Approaches to the Problem

So how does a company that may already have a comprehensive program at corporate headquarters reach its dispersed work force? Several approaches are possible. While not primarily designed for dispersed populations, the following models offer features that may be adapted to the needs of employees in scattered locations. Individual company and employee needs, company resources, corporate operating philosophies, and union policies will determine what course is taken.

Employee Assistance Consortium

Companies with too few employees to justify an independent inhouse program and other companies with similar staffing configurations in the same geographic area have joined forces to form a consortium. Administration is provided by a governing board consisting of representatives from the member companies, and arrangements are made with a local provider (mental health center, health clinic, alcoholism council) for counseling, assessment, diagnostic, and treatment services. The consortium is usually designed for small businesses, but can be equally effective with small divisions of a larger corporation (Godwin et al. 1978).

A component of the Lincoln Council on Alcoholism and Drugs in Lincoln, Nebraska, provides services to a consortium of 38 private companies and public organizations, representing over 14,000 employees in the greater Lincoln area. Initially lacking funds to operate independent in-house programs, several local business operators met in 1974 with the Lincoln Council on Alcoholism and Drugs and formed a Business Assistance Committee. Clients now range from a law firm of 14 employees to a school district of 3,000 employees, and 25 State agencies are served under a State contract. Developmental funding has been provided through a grant from NIAAA.

A key ingredient in the success of the Lincoln Employee Assistance Program (EAP) consortium is regularly scheduled meetings with company representatives. Project staff are particularly sensitive to the continuing maintenance of existing programs, and a substantial amount of staff time is spent on periodic followup, consultation, training and public outreach. These efforts are in addition to the basic range of services offered, which include:

- Technical assistance for developing company programs
- Supervisory training sessions
- Motivational counseling
- Referral of clients to community treatment providers
- Followup and aftercare
- Development and distribution of educational materials
- Provision of emergency counseling services upon request of the company
- Limited in-plant counseling services

An ongoing problem for staff is the challenge to assess and motivate the client to follow through, without doing unnecessary short-term therapy or outpatient care in the process. According to program staff (Isenberg 1980):

> *The more actual counseling the EAP client receives the less likely the client will be motivated to seek additional counseling in the community. The inherent problem is to define limits...so this process does not take the place of the treatment more appropriately performed in the community referral agencies.*

With this point in mind, client outcome measures have been built around successful referral to an outside agency, as well as resumption of satisfactory job performance.

In-house Alcoholism Program

Providing problem identification, referral, followup, and aftercare all at one location, an in-house alcoholism program may be applicable to major corporations with large branch operations. While this is probably the most effective method of providing a wide range of services to any work force, it is also the most expensive for small groups of employees. It requires extensive training and a network of salaried staff. It is now being used successfully by large companies with a large dispersed work force.

International Telephone & Telegraph (ITT) initiated 10 new in-house programs during 1979-1980, bringing the total on-site locations to 23. This in-house program, like many industrial alcoholism programs such as that operated by United Technologies, focuses on job performance, not alcoholism. The supervisor plays a key role in referral procedures. ITT plans to initiate further on-site programs during the coming years at other locations with large dispersed work forces.

Service Network

Formed by companies with established programs at corporate headquarters, service networks[2] are a means for extending this resource to company divisions and branches. The network is essentially an information and referral system for field employees that can be delivered by either a contractual service model or a company-controlled model. In the contractual service model, the company contracts with a service

[2]This term has been developed for this publication in order to describe a specific type of program used in several companies.

1969 NCA's Labor-Management Committee established.

1970 Enactment of the Hughes Act establishes NIAAA-funded State Programs.

1971 United Auto Workers International Executive Board adopts policy statement for joint union-management alcohol programs.

1971 Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) formed.

1972 First Federal Aviation Administration exemption for alcoholism granted to air transport pilots.

1972 NIAAA offers staffing grants to support the work of two Occupational Program Consultants (OPCs) in each State.

1973 Approximately 500 occupational alcoholism programs in operation nationwide.

1974 Seventy-five percent of Blue Cross plans (62 percent of Blue Shield) have some degree of alcoholism coverage available.

1974 Air Line Pilots Association Human Intervention and Motivation Study (HIMS) begins operation.

provider on a national basis. After an employee is referred to this provider, the contractor is totally responsible for employee counseling services. The second model features a central information and referral network operated through the corporate program. Employees are counseled from headquarters in a number of problem areas including alcohol-related problems. A company-operated 24-hour crisis line for employees and their families is common to both models, as is company established evaluation criteria for assessing the services provided to the employee with alcohol problems.

The Xerox Corporation, an employer with a sizeable dispersed work force, has used the contractual service model in offering help to its employees throughout its entire U.S. operations and piloting in Canada. Placing responsibility for service delivery of the program with an outside agency, Xerox contracted with a national social/health services organization that offers personnel resources and facilities to communities and corporations.

After assuring the confidentiality of the counselor-client relationship, the service provider and Xerox OAP personnel participated in training on the mechanics of the program, including procedures to deal with deteriorating job performance. The program is endorsed by the union, and their representatives received training in conjunction with management and supervisory personnel.

The second form of service network, the company-controlled model, is the approach taken by the Kennecott Copper Corporation. Seeking to improve upon available alcoholism programs and recognizing a need for dealing with work-interrupting personal problems, Kennecott Copper Corporation established its own direct, confidential source of help—INSIGHT. Started in 1970, INSIGHT today is a 24-hour crisis line operated by psychiatric social workers. The program is designed to handle a broad range of employee problems. INSIGHT has been well publicized throughout the company, and most of the callers initiate the hotline call on their own. In some instances, however, employees are directed by trained supervisors to use the hotline or face disciplinary action. After calling INSIGHT, many callers are referred to a trained counselor located within the company. A single meeting resolves the employee's problems in about one-third of the cases. In other cases, the employee is referred to a public or private social agency, the legal aid society, or a psychologist.

Alcoholism is one of the most frequent problems encountered—about 7 percent of the company's employees suffer from some degree of alcoholism—and INSIGHT seems to be dealing with it successfully. In a 2-year period, absenteeism dropped 44 percent (Jones 1975). Support has come from Kennecott's 19 unions (the major union is the United Steel Workers) that encourage their stewards to help members with alcohol problems by suggesting available resources, such as the 24-hour telephone line.

Selecting an Approach

Each of the approaches for delivering assistance to dispersed work forces has certain advantages and disadvantages. For example, consortia offer direct access to and knowledge of community resources and confidentiality of client records. However, because the program is usually separate from the work force, there is limited company control and limited physical access to services. The service network, on the other hand, provides equal services to all employees, regardless of location, and the company maintains final control; in this approach, continuity of care is limited and access to services is generally restricted to a 24-hour telephone line. The in-house program is an especially cost-effective approach for the large company, because as the number of employees rise, the cost per worker decreases, spreading costs over a larger number of persons.

The referral process, crucial to the success of any organizational alcoholism program, is another criteria to consider in selecting an approach to reach dispersed work forces. How referrals are handled in the consortium, the in-house programs and the service network are summarized below. Again, decisions on initiating programs for workers with alcohol problems will also hinge on individual employee needs, available resources, and overall philosophy of the company or union involved.

Summary of Referral Procedures

	Consortium	In-House Program	Service Network
Self	Employee goes directly to company contact person who makes appointment at central consortium office. (Self-referrals are usually not indicated on company personnel records.)	Employee goes directly to in-house program office. (Self-referrals are not indicated on company personnel records.)	**Contractual** Employee calls a crisis number operated by a local contracted agency. An appointment is made for assessment and referral. **Company** Employee calls a 24-hour company crisis number, receives crisis counseling followed by next day referral to a local service agency.
Peer or Family	Peer or family member makes appointment with company contact person to help employee, or appointment is made directly with consortium.	Peer or family member makes appointment with counselor/contact person in in-house program to help employee. (Peer or family referrals are not indicated on personnel records.)	**Contractual** Peer or family member calls crisis number operated by a local contracted agency. Assessment and referral are made by setting up an intervention. **Company** Peer or family member calls 24-hour service for intervention assistance.
Supervisor	Supervisor refers employee to in-house counselor or directly to central consortium office where client records are maintained.	Supervisor refers employee to in-house counselor/contact person. (Supervisor indicates only job performance problems on personnel records or evaluations.)	**Contractual** Supervisor contacts personnel department/similar department, which cordinates referral to services or supervisor can refer directly to contacted agency. **Company** Supervisor contacts company program, which recommends a referral service, or supervisor recommends program and employee sets up diagnosis and assessment interview with program representative.

Union Assistance to the Hard-to-Reach Worker

Programming Needs

Problem drinking that affects work performance has traditionally been regarded as a disciplinary problem and a matter to be handled by management. In the past, unions have been overlooked and sometimes rejected by management in developing alcoholism policies. Personnel and medical departments—usually management oriented—have often developed employee alcoholism programs without the participation of either supervisors or the union. In 1968, of 120 companies that had contemplated or started alcoholism programs, only 39 consulted their unions (Trice et al. 1977).

More recently, however, the vital place of unions in the development and support of employee alcoholism programs has been recognized, and union-based efforts have successfully introduced a number of creative program ideas.

In workplaces where a union is present, performance tends to be highly visible and often linked to the work of others. Foremen, supervisors, and union stewards observing a worker's performance are aware when performance declines. In dealing with a worker whose on-the-job performance is unsatisfactory, many unions use the confrontation approach. Union officers, shop stewards, or other union members confront the individual with evidence of declining performance, and at the same time, offer assistance in obtaining counseling. The worker whose performance does not improve may then be subject to disciplinary action from the company as defined in labor/management policy.

Union Sponsorship of Programs for the Hard-to-Reach

- Labor-management relationship already established
- Organizational structure in place
- Self-help tradition among union brothers and sisters
- Historical endorsement of worker health programs

But not all union members work under close supervision. Many work either on their own or in cooperation with other union members, but have limited regular contact with a supervisor. In commercial shipping, for example, merchant seamen regularly report to the union hall where a union representative, called a chief dispatcher, assigns seamen to jobs on ships in port. Changing locations and short duration of jobs make a management-sponsored alcoholism program impractical. In a sense, the union representative/chief dispatcher acts as a de facto supervisor in commercial shipping. This is also the case in other similarly structured occupations such as the construction industry. Alcoholism programs that maximize the use of existing positions, such as that of dispatcher, can be designed to meet the needs of hard-to-reach workers. Where supervision is limited, peer intervention can play a key role. Unions, well aware of the identification and service delivery problems in reaching special sectors of the work force with alcoholism services, have undertaken sponsorship of a number of innovative programs.

Approaches to the Problem

Unions not only represent the interest of their members, but also have established relationships with them. As advocates for improved worker wages and benefits, unions are in a unique position to assist members with alcohol problems. Member assistance programs (MAP), as some of these efforts are called, are currently operating for members of the International Longshoremen's Association, workers in segments of the building and construction industries, and members of the Air Line Pilots Association and of the National Maritime Union, among others.

Longshoremen

Union shop stewards in the International Longshoremen's Association (ILA) play a unique liaison role between workers and management, assuring that workers are assigned tasks consistent with negotiated agreements and that other conditions of employment on the

piers are within certain established parameters. The ILA Alcoholism Program has made judicious use of the shop stewards' unique role, providing continuing education and training to these individuals in the identification and referral of members with alcohol problems.

How effective is the motivation that union shop stewards provide? Even though it is not the role of the shop steward to offer a union member a firm choice between accepting help and accepting routine company discipline, the steward does have special leverage. Refusal to accept treatment can result in loss of one's "position" on a given pier, an event that may lead to reduced wages and/or less desirable job responsibilities. Thus shop steward intervention is a key element in program success.

Begun with an NIAAA grant in 1974, the ILA Alcoholism Program was formed through an agreement between the New York Shipping Association, Inc. (NYSA) (96 companies), and the International Longshoremen's Association of the port of greater New York (40 local unions). The program offers identification and referral to 20,000 employees and their 50,000 dependents. Treatment services are financed through the NYSA/ILA Welfare Fund and delivered by community providers for negotiated daily rates.

Referrals to the alcoholism unit may come from pier superintendents, dock bosses, union delegates, shop stewards, ILA welfare inspectors, and the ILA clinic. Upon receiving a referral, program staff discuss with the source the basis for the referral and review the client's medical record to investigate the possibility of a polydrug problem, history of medical illness and associated symptoms, or previous treatment for accident-related problems. During the initial appointment, which may also include a physical examination by a clinic physician, program staff make a determination of the affected individual's status and refer that person to an appropriate treatment facility.

Publicizing the program to encourage full participation by union and management alike is an important facet of the program's strategy. A front-page article in the Local 824 bulletin and a subsequent letter sent to every ILA member's home were used initially to draw attention to the effort. Articles have continued in various ILA publications, in addition to placement of posters in all clinics, hiring halls, union offices, piers, and terminals. The program director has addressed membership meetings and has traveled to all sections of the port, meeting with shop stewards, foremen, and pier superintendents, informing them about the program, and asking their cooperation. Program staff are also working to encourage clinic physicians to actively identify and refer those with alcohol problems to the program.

Building and Construction Industry Workers

Labor and management have joined forces in Westchester and Putnam Counties in New York to successfully organize many diverse groups within the two-county area to combat alcohol abuse in the building and construction industries. The Westchester and Putnam Counties Joint Labor-Management Board Alcoholism Program, initiated in April 1976, is funded by employers with some assistance from the building trades welfare funds. Additional funding has come from an NIAAA grant, awarded to the program in 1978.

Characteristic of the building and construction industries are close relationships among employers, supervisors, and workers that encourage a permissive camaraderie that may often hide the more visible signs of alcoholism. Added to this difficulty are the lack of knowledge about the disease of alcoholism on the part of employers and supervisors, the practice of hiring from a constantly changing pool of workers, and a constantly changing job site. Referral procedures have recognized these problems. Business agents who make job assignments and job stewards responsible for individual company projects are trained to spot signs of alcohol abuse.

Referral channels also include management officers, peers, and family. A project manager (supervisor) who notices unsatisfactory job performance will notify the union business agent who, in turn, contacts the field coordinator of the alcoholism program. At that time, an interview is scheduled with program staff. Peer participation in the referral process has been particularly successful, given the emphasis placed on the program's confidential nature and nonpunitive purpose. Further, it is thought that intervention at this point may have the greatest chance of preventing problems long before serious job impairment occurs. Family referral is encouraged through use of a direct telephone line offering immediate information and assistance. Dependent family members are also provided help with alcohol problems under this program.

In addition to serving construction workers and their employers, the program is open to building managers, service workers, and those in small companies related to building, as well as to employees of architectural firms, survey companies, title companies, materials suppliers, and real estate firms.

Airline Pilots

Peer-group-coordinated interventions within the organization can be successful

in motivating an alcoholic pilot to seek treatment. This has been the experience of the Air Line Pilots Association (ALPA) since 1974, when it developed a successful alcoholism program model for the airline industry, through an NIAAA-funded grant. At the center of the program is a peer group of ALPA pilot volunteers trained in alcoholism education, intervention, aftercare, and program development. Not intended to be either alcoholism counselors or diagnosticians, the pilot volunteers function as coordinators for all aspects of the program from referral to aftercare.

The experimental ALPA Human Intervention and Motivation Study (HIMS) program was initially designed to provide assistance to 10 percent of the ALPA members. However, demand for services required that the project be made available to all 35,000 pilots of the 31 U.S. airlines represented by ALPA. Critical to passenger safety and crew efficiency within the airline industry and to the subsequent design of this program is the issue that alcohol problems be identified long before job performance begins to deteriorate. Making accomplishment of this goal more difficult are Federal Aviation Administration (FAA) regulations that do not encourage alcohol-dependent pilots to report their problems or to ask for assistance. Given this, a referral process was adopted that emphasized significant peer involvement, with most referrals coming from the pilots themselves. Assistance to an alcohol-affected pilot usually begins with an intervention coordinated by a trained pilot volunteer, usually alerted to the individual's apparent condition by a fellow pilot. Intervention (confrontation) then occurs between the pilot and a concerned group that typically includes one or two fellow pilots, a representative of the trained volunteer group, an elected representative of ALPA, and occasionally a family member or management representative. Formal contact with the alcoholism program for assessment is next, followed by referral to appropriate treatment. The intent of this process is to bring about confrontation long before a problem of job performance decrement develops.

With their firsthand knowledge of the airline industry and FAA medical recertification procedures, the pilot volunteers are uniquely qualified to assist other pilots in overcoming fears regarding possible job loss. These volunteers also coordinate activities between the treatment facility, the company, and ALPA. For those who require inpatient treatment, the responsibility for coordination of aftercare activities is jointly shared with a labor/management committee and the project staff.

The primary program hurdle, according to the staff, is the education/communication task of convincing pilots, airline management, and the FAA that all parties must examine the problem of alcoholism in a nonpunitive manner. Ongoing promotional efforts—mailings to ALPA members, resource libraries in crew lounges, and presentations at union meetings—are doing much to address this problem.

Merchant Seamen

Focusing on the sense of fraternity inherent among merchant seamen, the National Maritime Union (NMU) Alcoholism Program stresses the use of support systems among crew members to help alcohol-abusing seamen. Intervention by fellow crew members on the ship brings an important personal dimension to the program and is instrumental in preventing serious job impairment problems. The support system also extends beyond the ship and includes bartenders in taverns and lounges frequented by seamen. Training for these individuals deals with problem drinking among seamen and recommends procedures for contacting union representatives to provide on-the-spot intervention. A prime goal of the alcoholism program is to continue to develop strong labor/management collaboration in assisting alcohol-troubled seamen to obtain treatment.

Before the NMU initiated its program with a grant from NIAAA in 1978, many seamen with alcohol problems had good reason to hide their drinking problems. A seaman discharged from the vessel for drunkenness on the job could be "blacklisted," reducing his chances for further employment, since maritime employers are relativley few in number. Among seamen, the tendency has been to protect one another, thus drinking problems have been concealed. The NMU program, which now serves a population of over 17,400 persons—active seamen, retirees, and dependents in New York, Connecticut, and New Jersey—has gone a long way to change that practice.

Program referrals originate from a number of sources, including the offices of New York-based shipping companies that advise the alco-

holism program of seamen dismissed from their jobs for poor performance due to alcohol abuse. Beyond that, the program depends on referrals from three main sources:

- *NMU Patrolmen* are union officials authorized to identify crew members facing disciplinary action for unsatisfactory performance. They meet with the ship's union stewards and refer seamen who are experiencing drinking problems. Because of their special advocacy role, they are in an advantageous position to monitor and identify problem drinkers.
- *The NMU Medical Department* examines seamen before every voyage to determine their fitness for service. A seaman who appears to have medical symptoms of alcohol abuse is promptly referred to the program. A medical release is required before that person may assume sea duty.
- *The U.S. Coast Guard is* the overall legal supervisor for the entire U.S. Merchant Marine fleet. The Coast Guard's role includes issuing the seaman's certifying documents for employment aboard ship, monitoring job performance, and taking appropriate action for poor conduct on the job. Such performance thought to be related to alcohol, however, is handled under the provisions of a joint policy statement of the Coast Guard and the National Maritime Union Alcoholism Program. This policy statement, governing the entire merchant marine fleet, provides that a seaman brought before an administrative law judge by a marine inspector will be referred to the program. Disciplinary action is withheld during treatment and charges may later be dropped on recommendation from the inspector and the union.

A key element to program success rests on the project's continuing efforts to sensitize union and management personnel to alcoholism and alcohol abuse through training and education. This includes training of the medical unit staff, union officials, shipping company personnel, Coast Guard liaisons, and NMU students enrolled in upgrading and retraining plans. Informing individual union members and their families about the program is a major part of this education effort. Regular mailings are sent to the seamen's homes. The program is discussed regularly at union meetings, and some feature of it is covered in each issue of the "PILOT," the NMU newspaper. Literature on alcoholism and the program is placed aboard ships and in seamen's clubs in foreign ports through an agreement with the United Seamen's Service; a quarterly newsletter for program participants, specifically geared to the community of seamen in recovery, is widely circulated.

Selecting an Approach

Hard-to-reach workers affiliated with a union are already part of an existing organizational structure that potentially can be tapped to assist members with alcohol problems. Those elements important to the development of member assistance programs—relationship with management and endorsement of worker health programs—are basic policies of most unions. The special characteristics of the occupations referenced in this chapter—changing employers, constantly varying work sites, long periods at sea—make these workers hard-to-reach for both identification and referral as well as for service delivery for alcoholism problems. Although seemingly unique to the groups just described, these characteristics and conditions may indeed be very similar to other hard-to-reach occupations. Program features that are succeeding—peer volunteer coordinators, use of business agents/union representatives as intervenors, agreements with involved regulatory entities such as the Coast Guard—can be adapted to suit the programming needs of a variety of populations. Union affiliation is an available mechanism that can be used to organize and implement employee alcoholism programs for hard-to-reach workers.

Other Professions

Programming Needs

If they work for an organization such as a law firm, health maintenance organization, or university, other professional people[3] receive little direct supervision on a day-to-day basis. If they work for themselves, they have no supervisor to provide feedback on their performance. They are highly motivated people who have gone through strenuous years of education or apprenticeship.

This category of workers includes lawyers, clergy, engineers, executives, university professors, doctors, dentists, and others who practice a vocation or occupation requiring advanced training in liberal arts or science. Generally, this group is characterized by a relatively high degree of self-regulation implemented through peer organizations. Physicians and lawyers, for example, carry out self-regulation through well-organized State licensing bodies.

The stress and responsibilities of their jobs place these workers at high risk for developing alcoholism, yet their status, their independence, and their control over their own careers place them beyond the reach of most alcoholism programs.

[3]In recent years, society has broadened its concept of the term "professional" and has come to recognize more and more occupational groups as professions. Toward this view, all the workers discussed in this booklet are professionals and the title of this chapter addresses yet another category of workers who are hard-to-reach for alcoholism programs.

Employee alcoholism programs have normally been based on a formal labor-management structure. They operate under the assumption that the most clearcut mechanism for identifying alcohol problems is the supervisor's or shop steward's awareness of unsatisfactory performance. Frequent supervisor contact, an important component of most programs, is not usually possible where members of some professions are concerned. Roman (1976) notes of university professors:

> *The documentation and measurement of deteriorating performance of a faculty member could rest only upon blatant indicators such as repeated absence from class or specific deviant behavior while on the job. It is likely that such behavior would be indicative of the latter stages of an alcohol or other personal problem and would not facilitate early identification.*

In addition, as Roman points out in his article, deviant behavior in many professions, particularly university faculty, appears to be more acceptable than in other jobs. This very autonomy makes is difficult to proceed with any of the supervisor-based structure of the traditional program. Lack of direct supervision then represents a significant barrier to the establishment of programs for this population group.

1975 International Lawyers in AA established.

1976 University of Missiouri establishes employee assistance program for faculty and staff.

Programming Barriers

- High degree of autonomy
- Lack of formal supervisor/worker structure
- Protective network among colleagues
- Pressure to maintain appearances and to socialize with alcohol

Another factor making it difficult to reach this group is the existence of strong protective networks among colleagues. There is a tendency to adopt a hands-off attitude where problems such as alcoholism are concerned. One physician with a drinking problem did not remember he performed a tracheotomy. Nurses and other physicians were aware of his problem, yet they constantly made excuses and covered up for him. And Jack Sanow, director of the California State Bar Committee on Alcohol Abuse, notes that people cover up for lawyers "in a way they would not for truck drivers or salesmen" (Kneightley 1976).

Job status and the accompanying self-image —the need to keep up appearances—is another factor inhibiting referral and treatment for alcoholism. Many lawyers refuse to go to AA fearing loss of business, and many executives are reluctant to use AA for a similar reason. One bank president confronted a branch manager about his drinking problem, but demanded that he refrain from attending AA meetings as this would reflect negatively on the bank's image.

Difficulties are compounded by the social tradition of drinking often seen as the key to acceptance by other colleagues. And for some, increased leisure time and income have made liquor more accessible, thus increasing consumption. Cassell (1977) quoted a substance abuse program director's explanation of a dentist's situation:

The guy in his 10th or 15th year of practice can afford not to work when he doesn't want to. He can relax some. And that's the real danger point. All of a sudden alcohol is as economically feasible as water.

In considering the factors that make individuals in these professions hard-to-reach, it should be noted that such persons are hard-to-reach in terms of both identification and referral into treatment. However, given their tendency to carry out their job functions in a minimum of locations—hospitals in a limited geographic area, a single university campus—they are certainly reachable in terms of service delivery, assuming that treatment alternatives are available and are acceptable to those individuals with alcohol problems. Further, membership in a peer association offers a potential supportive network of colleagues who can be involved in the identification and referral process. These factors offer opportunities for designing service programs that are truly sensitive to the needs of physicians, lawyers, dentists, university faculty, and others working in settings with similar occupational characteristics.

Despite their autonomy, protective networks among colleagues, and pressure to maintain appearances that characterize this group, a number of successful alcoholism programs have been established. By using the support and involvement of peer organizations, such as bar associations and medical societies, concerned colleagues are beginning to alert others within their individual communities to the alcohol problems that have long been denied. Referral-only programs have been established as well as those offering a comprehensive array of services, from identification, referral, and treatment in specialized facilities to aftercare.

Approaches to the Problem

Programs for lawyers, physicians, and university faculty are demonstrating unique ways to reach colleagues, treat them, and return them to productive work within their respective job settings.

Lawyers

Stress Factors

Lawyers are always giving advice to other people, but resist taking it themselves. When you're with attorneys, you're in court. They can offer a thousand excuses why they drink (Sanow, cited in California Bar Association 1979).

Unhappy clients, many of them in trouble, face an attorney every day. Some clients are unreasonably demanding. They understand little of the work the lawyer does, and often they are ungrateful. The need for great attention to detail fosters a stressful environment for the lawyer. Antagonism is a professional necessity, and delay in the courts can be frustrating. In addition, a lawyer who does not work for a large firm must be a business administrator. Lawyers must be especially concerned with appearances and cannot, in their profession, afford to "lose face."

No national data are available on the number of attorneys with alcohol problems. There are, however, approximately 445,000 attorneys nationwide (American Bar Association 1980), and if one accepts the estimate that 10 percent of the U.S. population suffer from drinking problems (NIAAA 1978), it can be surmised that perhaps 44,000 individuals in the legal profession are experiencing problems with alcohol. Given the size

of this population, it is apparent that some clients, in and out of court, are not being adequately served by their attorneys and presiding judges, and that the legal profession, in some cases, may not be performing at its maximum potential.

Programs for Lawyers

The impact of alcoholism and its implications for the effectiveness of the legal profession and the welfare of its members is of great concern to State and local bar associations. Their response has resulted in the establishment of approximately 35 alcohol abuse programs at State and local levels[4] (Kneightley 1976). The first program began in California and has served as a model for subsequent programs that have evolved in other parts of the country.

In 1973, the State Bar Association of California established a committee on alcohol abuse to oversee a treatment program created especially for lawyers and judges. As most members of the bar with alcohol problems had declined to attend AA meetings because they felt it would be harmful to the image of their profession or to their own businesses, private meetings among attorneys only were initiated for these members. This method of assistance, similar to AA, has been widely accepted. Common backgrounds have been important in making participants feel comfortable in a setting with peers (Saeta 1978).

Referrals come from a variety of sources including self-referral or referral from a colleague, a family member, or a judge. When an attorney joins the group for the first time, three other recovering alcoholic attorneys in the program are assigned to the new member. They explain the program and keep in close contact with the individual for a number of weeks. After about 6 months in the program, the individual may be assigned to a new incoming member.

For years the committee on alcohol abuse ran a small ad in a daily law paper read by 85 percent of the attorneys in California. That ad, with a brief announcement of the program, and word-of-mouth dissemination, resulted in hundreds of calls. Then, in 1978, the alcohol abuse committee entered into an agreement with the disciplinary committee of the State Bar Association, an event that significantly increased the outreach capability of the program. Members brought before the bar on disciplinary charges can now be referred to the program to determine if alcohol is a contributing factor in the disciplinary problem. Participation in the alcoholism program is regarded as a probationary period for the attorney. Of those referrals from the disciplinary committee, approximately 50 percent of the cases have stemmed from citations related to driving while under the influence.

From a single organization 7 years ago, the California program has grown to 35 groups across the State. Each group holds a weekly recovery meeting for members from nearby areas. Like other bar activities conducted in similar weekly sessions, regularly scheduled meetings fit into a pattern familiar to attorneys. This self-help philosophy is a main theme of the California effort, beginning early on with lawyers making their peers aware of the program and encouraging those with problems to seek treatment long before job performance declines. Such as approach has evidently been effective. Since 1973, 900 lawyers and judges have participated in the program and almost two-thirds of that group are now completely free of alcohol problems (California Bar Association 1979).

The California bar association's committee on alcohol abuse believes that the ultimate success of a program depends on the active participation of local bar associations. Local contacts, with their knowledge of the area's legal culture, assist in designing treatment programs tailored to individuals in need of assistance.

Numerous other programs have emerged—Minnesota Lawyers Concerned for Lawyers, New Jersey Lawyers Concerned for Lawyers, the Michigan Lawyers and Judges Counseling Program, to name just a few. Program features common to these State bar efforts are weekly recovery meetings, involvement of recovering peers in identification and rehabilitation, and assurances of confidentiality. Differences among established programs range from the use of disciplinary committees, avoidance of the disciplinary approach in policy statements, the use of hotlines, contracts with health providers to staff the program, to totally volunteer staffs. Local preferences as well as available resources are factors in shaping the program to serve the needs of lawyers whose involvement with alcohol has become a concern of their colleagues.

Physicians

Stress Factors

Until doctors get used to it, treating another doctor is like looking in a mirror—confronting things in themselves. It took us quite a while, but now the special treatment we offer doctors is to forget what they do for a living (Bissell and Jones 1976).

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[4] As of September 1979.

Like lawyers, physicians' work entails long hours, considerable responsibility, and little leisure time. In addition, as Nye (1979) has noted, there is disillusionment with the humanitarian expectations of medicine, and many physicians have difficulty in accepting the limitations of their own strengths, energy, and talents and the limitations of medicine itself. Expectations to simultaneously serve a number of very different roles—doctor, business manager, employer, community leader, social worker, spouse—exert continual pressure.

Physicians today are under a number of additional stresses. A study of alumni of Case Western Reserve University indicates that today's physicians feel pressure to practice "defensive medicine" and find it increasingly stressful to take any risks in the medical management of their patients; they fear reprisal against themselves and their families from disgruntled patients, and also fear anxiety about peer pressure to report incompetent colleagues (Mawardi 1979). The effect of covering up for incompetent colleagues, particularly in the case of drinking problems, delays the treatment and rehabilitation process, resulting in a disservice both to the affected individual and to the medical profession as a whole.

Statistics on the number of physicians experiencing alcohol problems are relatively scarce because doctors are reluctant to report themselves or their colleagues as alcoholic, and ongoing programs sponsored by medical societies and other organizations are unwilling to release figures for reasons of confidentiality. On the basis of statistics for the general population, in which approximately 10 percent or more are estimated to be alcoholic, it has been suggested that 13,600 to 22,600 of the Nation's 324,000 physicians may be experiencing alcohol problems severe enough to impair work performance (Bissell and Jones 1976).

Programs for Physicians

The impaired physician is the subject of legislation in more than one-half of the States, and an almost equal number of States have medical society programs for this purpose (Robertson 1978). Many of the physicians' programs operate along the same basic lines, including:

- Maintenance of a strong relationship with the State licensing board, although program control is never a function of this relationship
- Involvement of the recovering alcoholic physician in the referral and treatment of other physicians
- Placement of treatment plans under the auspices of the State medical society
- Recognition of confidentiality as a high priority

Impaired physicians' programs are still in a stage of early development, and approaches vary from State to State. Some medical societies prefer a low-profile approach, with few or no records kept; others are more active in casefinding. Some programs operate on a county level, but others function on a statewide basis; some find the linkage with the State licensing board more effective.

The Georgia Disabled Doctors Program, for example, regularly makes recommendations on suspension or cancellation of medical license to the State board. This program, which began in September 1975, has available a 30-bed inpatient treatment center established mainly for the rehabilitation of disabled physicians. Since 1976, 233

1977 2,400 employee alcoholism programs are at some stage of development in public and private employment centers in all 50 States.

health professionals, most of them physicians, have been referred to the program. Funded by the Medical Association of Georgia, the Disabled Doctors Program is structured around the activities of two association committees: the Physicians Consultant Committee and the Professional Conduct and Medical Ethics Committee.

Primary emphasis is on the Physicians Consultant Committee program component committed to encouraging the physician to enter and to remain in the program. This committee, composed of recovering alcoholic physicians and those with experience in addictions, is involved in identification, treatment planning, and followup for each individual physician. Committee members also provide encouragement and moral support to the impaired physician, the family, and friends. Physicians with alcohol problems are usually referred to the committee by pharmacists, family, hospital staff, nurses, or other doctors who have used the program's services.

Only after all efforts by the consultant committee have failed will the Professional Conduct and Medical Ethics Committee be called upon. On the basis of available information, the ethics committee may decide, by majority vote, to make a recommendation to the State Composite Board of Medical Examiners to suspend, revoke, or restrict the license of the doctor in question. At this point, no one with the medical association can any longer be an advocate for the physician.

Programs in other States utilize many of the techniques and approaches taken in Georgia, and one State, California, has seen two separate programs emerge to serve the diverse needs of its physician population. A 24-hour hotline, the Physicians' Confidential Line, is operated by the Alcoholism and Other Drug Dependencies Committee of the California Medical Association (CMA), a private State-level organization of doctors. The members of this committee rotate hotline duty, responding to callers through discussion of the problem and suggestions on treatment facilities or therapists in the impaired doctor's area of residence. Self-referral is a requirement of the Diversion Program operated by the Division of Medical Quality of the State Board of Medical Quality Assurance. This is probably the only program of its type in the country whereby a governmental regulatory agency, by legislative authority, allows diversion of physicians from the disciplinary process to a rehabilitation program, without threat of sanction against the physician's license. Friends and colleagues may also notify the program about a particular physician, but the program takes no action until the individual admits him/herself. Drug abuse, mental illness, physical disabilities, and other disabling programs are also dealt with as part of the Diversion Program's commitment to protect the public while simultaneously treating the physician for return to productive practice.

No formal ties exist between the California Medical Association's Hot Line Program and that of the California State Board; however, it seems probable that given the referral nature of the Hotline, callers may be directed to the Diversion Program. Exploratory meetings between the California Medical Association and the Board of Medical Quality Assurance have been initiated to consider this liaison.

University Faculty

Stress Factors

Within these (academic) traditions is intense respect for individual freedom, coupled with an atmosphere which in many instances is not only marked by tolerance of sharp differences in style and behavior, but actually includes encouragement of eccentricities (Roman 1976).

While academicians are often envied by other professions for their relatively unstructured and "free" working environment, the pressures of life on campus are very real. Declining student enrollments have closed entire academic departments and have increased competition for the remaining faculty positions. The well-known stresses of the "publish or perish" philosophy are especially strong among young, untenured faculty, with whom formal performance reviews by senior staff are becoming more popular as a means of measuring teaching and writing activities. These stresses exert pressure on university professors to reconcile opposing rolls, in this case, between the scholar/researcher and the teacher/performer. In addition, "career peaking" is common among university professors unable to anticipate the next step in their careers (Roman 1977).

According to the National Center for Education Statistics of the U.S. Department of Education, in 1978-79 the number of instructors employed full time in 2- and 4-year institutions totaled more than 395,000.[5] Like the legal and medical professions, university faculty groups do not collect data on the scope of alcohol problems among their members. Again, it is possible to make a rough estimate that perhaps 10 percent of that population may have drinking problems.

[5]U.S. Department of Education, National Center for Education Statistics: personal communication, 1980.

Programs for University Faculty

More than 66 campuses nationwide are either operating or developing alcoholism programs, some with multiple campus locations (Hagen 1979). Programs responding to a 1979 University of Missouri survey placed high emphasis on the appropriate administrative location of the project, rating the employee personnel department as the most effective in securing the confidence of the potentially wide range of faculty and staff clients involved. Funding, a critical issue facing both new and existing programs, came from a number of sources, including college and university funds (hard dollars, in-kind services, release time), State funds, and Federal agencies, although some projects operated exclusively with volunteered time and services. In addition to providing early identification and referral for alcohol-troubled faculty and staff, some campus programs provide consultation to other academic institutions interested in starting alcoholism programs.

The majority of university programs have focused on all sectors of the academic community—instructional, administrative, and support levels. The academic sector, according to Richard Thoreson, Project Director of the University of Missouri Employee Assistance Program (EAP), is still the most difficult to reach, however. One suggested approach to this problem is to use the success and credibility gained with the nonacademic employee referrals as a means to penetrate the academic, managerial population (Thoreson 1976).

A pioneer in the development of university faculty programs, the University of Missouri EAP offers technical assistance to other academic communities concerned with alcohol problems. Begun with an NIAAA grant in 1976, the program addresses alcohol, drug, marital, parent-child, and legal problems that may contribute to declining job performance.

An element of the program that is especially appealing to faculty members is the use of a community-based treatment agency, rather than an existing university-sponsored resource, for referrals. This approach encourages self-referral, important to academics accustomed to a high degree of autonomy in their working environments. The program also stresses colleague involvement in reaching affected faculty and encouraging them to seek treatment.

Administratively, the Missouri program is made up of a two-tiered system of advisory groups: a Coordinating Council, composed of Dean-and Provost-level personnel (high-level administrative support), and a Project Advisory Committee, composed of representatives from all of the constituent groups involved with the project—academic, supervisory, support, and labor. The program is located within the office of the Provost for Health Affairs, a "neutral territory," where the program is not viewed as the particular province of any one department. This administrative location provides maximum exposure and credibility and establishes the program as a resource developed to meet the health care needs of valued university staff.

With a population of 2,000 academic employees and their families, the University of Missouri represents a diverse academic community that has taken positive steps to deal with alcoholism on campus. Program officials feel that a significant part of the program's success is attributable to the support given by high-level university administration officials.

Other universities, convinced of the potential cost benefits of campus alcoholism programs, have enthusiastically established programs. The Employee Assistance Program of the Rochester Institute of Technology, for example, is credited with saving the institution more than $300,000 in its first year of operation. This was calculated in terms of decreased absenteeism, reduced workmen's compensation and health benefits, and employee turnover savings (Rochester Institute of Technology 1977). Campus programs, such as those at the University of Missouri, the Rochester Institute of Technology, and 64 other known programs located across the country, are reaching alcoholic faculty with identification, referral, treatment, and rehabilitation services.

Selecting an Approach

The high degree of autonomy, lack of formal supervisor/worker structure, protective networks among colleagues, pressure to maintain appearances, and other characteristics that typify persons in certain professions are all factors that make these individuals hard-to-reach in terms of both identification and referral into alcoholism treatment. Groups of concerned lawyers, physicians, and university faculty have taken steps to meet the service needs of their colleagues. Elements of these programs, described in this section, may be adaptable to simular populations with alcohol problems. For example, nurses, social workers, psychologists, and those in the allied health professions, like lawyers and physicians, generally belong to a peer association. Service to these workers could conceivably be carried out through an association program that featured elements such as peer referral, involvement of recovering members in the rehabilitation process, coordination with State licensing bodies, and 24-hour hotlines operated at the

State level to refer individuals to local treatment and assistance resources.

The following chart highlights the efforts described in this chapter, and in addition, includes a program for dentists that shares staff and office space with the Minnesota lawyers program, but maintains separate records and program operations. Some overlap exists between referral mechanisms and methods for reaching the populations described here, particularly as peers are involved in these processes. Thus the "referral" column below also relates to mechanisms for reaching affected workers.

Summary of Programs

Population	Referral	Sanctions	Program Highlights	Operating Program
• **Lawyers**	• Spouse, colleagues, or judge to program	• Probation • Disbarment	• Active participation of local bar associations • Program autonomy • Emphasis on confidentiality	California Attorney Alcohol Abuse Program State Bar of California 555 Franklin Street San Francisco, California 94102 (415) 561-8228 Contact: Russell Longeway, J.D. Program Coordinator
• **Physicians**	• Medical society to State medical board; peer, family, or self-referral	• State licensing board can revoke license	• Support of local medical societies • Program autonomy • Emphasis on confidentiality	Disabled Doctors Program 3995 South Cobb Drive Smyrna, Georgia 30081 (404) 435-2570 Contact: G. Douglas Talbot, M.D. Director
• **University Faculty**	• Self, peer, or department chairperson	• Tenure denial	• Faculty-supported programs • Emphasis on confidentiality	University of Missouri Employee Assistance Program 215 Columbia Professional Building Columbia, Missouri 65201 (314) 882-6701 Contact: Richard Thoreson, Ph.D. Director
• **Dentists**	• Self or peer	• Probation	• Support of dental association • Emphasis on confidentiality	Dentists Concerned for Dentists 417 Minnesota Federal Building Minneapolis, Minnesota 55402 (612) 339-1068 Contact: Diane Nass, Director

Program Startup

Planning the Program

Target: Alcohol Abuse in the Hard-to-Reach Work Force has offered some ideas on how others have provided services to the hard-to-reach work force. While the groups described here may not be identical to the many remaining underserved populations, it is hoped that the approaches offered may include elements adaptable to these groups.

An earlier section of this booklet ("Definition of the Hard-to-Reach Work Force") discussed items such as changing work settings and multiple employers that should be considered in developing programs for hard-to-reach workers. Beyond those items, planners should also examine the nature of the identified population in terms of possible affiliation with a peer organization or union, or the degree of supervision involved. If, for example, the work force is affiliated with a peer organization, it may be possible to encourage the organization to provide services for its members, as lawyers, physicians, and dentists have done. In the presence of a strong union affiliation, a joint union/management program may be established. If neither of these is the case, as in a large company with small divisions, the consortium or service network may be appropriate. Information on the degree of supervision involved is key to the design of the program. It is a basis for determining the identification and referral procedures that will most closely suit the needs of the identified population.

Because the planning stage is complex and crucial to the success of the program, it is wise to seek outside advice. Sophisticated help is available, and most people are very eager to talk about their successes and sometimes their failures. To assist the program planner in conceiving and organizing services for the hard-to-reach work force, the remaining pages of this booklet offer some additional information and resources.

Elements of a Policy Statement

The first major task in beginning any employee alcoholism program is the development of a statement articulating the sponsor's policies with regard to alcoholism and the workplace and the appropriate roles of all concerned in the proposed program. As a basic frame of reference, this policy statement guides planners in the startup and implementation tasks and spells out the benefits and responsibilities of individual participants—labor, management, peer committees, clients—in the program. Most alcoholism programs operating today began with the adoption of a policy statement. While these ongoing programs have been designed to serve particular populations, they are all concerned with the same basic principles.[6] These include:

- The purpose of this policy statement is to assure confidential, professional assistance to individuals with alcohol problems, as is the practice with any other illness.
- Alcoholism is defined as a disease in which alcoholic beverage consumption repeatedly interferes with that individual's personal, social, economic, and physical well-being.
- Alcoholism is a progressive disease that can be treated effectively, usually without interruption of employment.
- Persons who suspect that they may have a drinking problem are encouraged to seek diagnosis and treatment that may be provided by qualified professionals, in order to arrest the disease as early as possible.
- Persons diagnosed as alcoholic are entitled to the same consideration and offer of treatment that is presently extended under existing benefit plans to those suffering from any other disease.
- The same benefits and insurance coverages provided for all other disorders under established benefit plans should be available

[6]Portions of this policy statement were adapted from *A Joint Union-Management Approach to Alcoholism Programs*, National Council on Alcoholism (1975).

for individuals who accept medically approved treatment for alcoholism.

- Job security and promotional opportunities will not be jeopardized by a person's request for diagnosis and treatment; disciplinary action within and by the organization (employer) will not occur unless job performance continues to be unsatisfactory.
- Volunteers, members, counselors, etc., are not medically qualified to diagnose alcoholism, but they can recognize negative changes in work behavior and make coworkers aware of the program.
- The decision to request diagnosis and accept treatment for alcoholism rests exclusively with the individual.
- Program records of individuals with alcoholism problems will be maintained as confidential.

Programming Considerations

Although the hard-to-reach work force demands some creative approaches in identifying mechanisms to replace the role of the supervisor or union steward and in identifying and referring special groups such as dispersed work forces, there remain basic considerations that are of concern to all alcoholism programming efforts, regardless of target population. Some programs will be union/management efforts; others will involve organizations such as medical societies or peer associations. The following are issues to consider in developing a program. They are offered in a very general sense since individual employment groups will vary in their structures, philosophies, and operations, and in their response to employees/members with alcohol problems.

Administrative Location. Where does the program fit into the organizational chart? Is the program freestanding or is it associated with an existing entity; e.g., medical, personnel, industrial relations, or safety department, or union, or organization committee?

Confidentiality. How and where are records stored and disposed of to assure confidentiality? How are support staff (clerical, secretarial) and accounting staff trained to protect confidentiality?

Continuity of Care and Followup. How smoothly can a client go through the system from point of identification, assessment, and referral to treatment? After treatment, what services does the program provide, such as regular appointments, group counseling, and referral to related community resources?

Convenience. Do program clients, supervisors (if applicable), union representatives, and peer organization participants have ready access to the program and program staff?

Education and Training. What are the company's/organization's training objectives? Who is the training audience: supervisors, management, union or labor representatives, or organization representatives? How much time can be devoted to training? What is the training content? Is the program promoted to all employees/members?

Insurance Coverage. Does present health insurance cover inpatient and outpatient services provided by the employer, particularly alcoholism treatment?

Program Evaluation. Are convenient and effective evaluation mechanisms built into the program? How will data be collected and analyzed? Who will be responsible for doing this?

Program Staffing. How many people are required to run the program? What are the staff education, training, and experience requirements?

Program Visibility. How is the program promoted through newsletters, brochures, etc.? Is corporate/organization/union headquarters willing to develop promotional materials for distribution: films, slide presentations, brochures, posters, etc.? Are other divisions (medical, personnel, safety) willing to promote services within their program activities?

Recordkeeping. Does the program have client intake forms? Is there an established procedure for recordkeeping? Can records be easily used for confidential evaluation purposes?

List of Relevant Organizations

The following organizations can provide information on employee alcoholism programs that may be helpful in planning programs for hard-to-reach population groups. This list, organized according to occupational group, is by no means exhaustive, but is offered as a starting point.

General

Al-Anon Family Groups Headquarters, Inc.
P.O. Box 182
Madison Square Station
New York, NY 10010
(212) 481-6565

Alcohol and Drug Problems Association
of North America
1101 15th Street, NW
Suite 204
Washington, DC 20006
(202) 452-0990

Alcoholics Anonymous (AA) World Services, Inc.
Grand Central Station
Box 459
New York, NY 10017
(212) 686-1100

Association of Labor-Management
Administrators and Consultants on
Alcoholism (ALMACA)
1800 North Kent Street
Arlington, VA 22209
(703) 522-6272

Hazelden Foundation
Community Services Department
Box 11
Center City, MN 55012
(612) 257-4010

National Clearinghouse for Alcohol Information
(NCALI)[7]
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600

National Council on Alcoholism (NCA)
733 Third Avenue
New York, NY 10016
(212) 986-4433

National Institute on Alcohol Abuse and
Alcoholism (NIAAA) Division of
Occupational Alcoholism Programs
5600 Fishers Lane
Rockville, MD 20857
(301) 443-6317

Clergy

National Clergy Council on Alcoholism (NCCA)
3112 Seventh Street, NE
Washington, DC 20017
(202) 832-3811

American Lutheran Church
Director of Support Services
422 South Fifth Street
Minneapolis, MN 55415
(612) 330-3100

Labor Unions

AFL-CIO
Community Services Department
815 16th Street, NW
Washington, DC 20006
(202) 637-5000

Air Line Pilots Association (ALPA)
12000 East 47th Avenue
Suite 117
Denver, CO 80239
(303) 371-0425

United Auto Workers
Community Services Department
8731 East Jefferson Avenue
Detroit, MI 48214
(313) 926-5513

Legal

American Bar Association (ABA)
77 South Wacker
Chicago, IL 60606
(312) 947-4062

Medical

American Medical Association (AMA)
Department of Mental Health
535 North Dearborn
Chicago IL 60610
(312) 751-6574

Faculty

University of Missouri
Employee Assistance Program
400 Hitt Street
Columbia, MO 65211
(314) 882-6701

[7]This organization has compiled "Occupational Alcoholism Programs Bibliography," an annotated guide available at no cost; other related materials are also available.

Glossary of Terms

Language is constantly changing in any field, and new terms need to be defined. Some of the following terms are currently in use and have been defined by those in the alcoholism field; others have been defined for the purposes of this booklet. Definitions have been drawn from articles and books listed in the selected references section.

Alcoholism: A disease in which alcoholic beverage consumption repeatedly interferes with that individual's health and/or satisfactory job performance.

Consortia: A number of companies or work organizations acting collectively to develop an employee alcoholism program under the administration of a governing authority consisting of representatives from member companies.

Dispersed Work Force: The population of employees that is characterized by work settings long distances from corporate headquarters and/or small numbers of employees at any one location; this group constitutes one segment of the larger, hard-to-reach worker population.

Employee: A person hired by another or by a business firm, etc., to work for wages or salary.

Employee Assistance Program (EAP): This program model uses the structural characteristics of the work world as an environment for early identification of the problem drinker and as a motivation for treatment. Other problems including drug, marital, legal, mental health, financial, and family are also handled.

Hard-to-Reach Population: The universe of employed and self-employed workers, who, for various reasons, have not been (or cannot be) serviced by traditional organizational alcoholism programs; this group may include members of the dispersed work force, the mobile work force, and selected other professions.

Member Assistance Program (MPA): Title used to refer to employee alcoholism programs designed for members of unions. Programs of this nature function on a unilateral basis, providing the same range of services to all participants in the program.

Mobile Work Force: Population of employees in the hard-to-reach work force whose employment requires frequent movement between geographic areas; this includes those in traveling sales, the transportation industry, and other similar employment.

Occupational Alcoholism Program (OAP): A program designed specifically for the identification and referral of the problem drinker in the workplace; unlike the EAP, this kind of program does not usually include other kinds of problem areas.

Peer Organization/ Association: A group of persons working in the same profession or occupation who affiliate for purposes of promoting members' mutual interests, such as continued education or upgrading of skills, political representation, and regulation or standard setting; such associations include teacher associations, bar associations, medical and dental societies, associations of nurses, social workers, and others.

Referral: Two basic categories are addressed in this booklet: (1) Program referral is the procedure by which the

troubled individual reaches the organization's alcoholism program; source of the referral may be the union, peer, family, or self; (2) Treatment referral is the procedure by which a couselor or other trained person facilitates the employee's entry into treatment.

Service Network: An information and referral program, monitored by the corporation EAP; the EAP establishes its own evaluation criteria for the resources to which the employees are referred. A company-operated 24-hour crisis number for employees and family is often a feature of the service network.

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